Data Source: Child Death Review Teams

Description: Child death review teams are state-level multidisciplinary teams that review child deaths, including suicide, with the ultimate purpose of preventing deaths to other children. The purpose is to pinpoint areas in which the safety net failed the child and could be improved. Almost every state has a child death review team.

Sponsoring institution: The National Center on Child Fatality Review (NCFR) developed and promotes the nationwide system of Child Fatality Review Teams that operate on the state level.

Data:

- Some states require a review of all deaths of those ages 0–17
- Other states focus only on injury deaths, deaths among very young children, or suspected abuse cases.

Variables: The variables differ by state but usually include:

- Circumstances
- Cause of death
- Contributing factors

Source of data: Child Death Review Teams base their reports on existing data sources, including the following:

- Birth and death certificates
- Medical examiner's reports
- School records
- Other medical reports
- Child protection service reports
- Civil and criminal court records and police reports

Strengths:

- Reviews can reveal suicides that have been misclassified in other data sets.
- Reviews can also provide detailed information about youth suicides, such as precipitating factors, types of help sought, and barriers to care.

Limitations:

- Information is very inconsistent across local and state jurisdictions.
- The data are often not computerized or made publicly available.

Access:

- For more information, go to the National MCH Center for Child Death Review.
- To find child death review teams for specific states, go to http://www.childdeathreview.org/state.htm.
- Although no individual case data are publicly available, some states publish reports with aggregated data. See the Rhode Island report focused on youth suicide.